

STATE OF DELAWARE

2019 Flexible Spending Account Plan Booklet



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INTRODUCTION

A Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck before they are taxed and put them into a special account.

FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes. FSA participation will impact earnings reported to the Social Security Administration. In accordance with Internal Revenue Code Section 125, allowable premiums for health, dental and vision insurance are currently taken on a pre-tax basis. The more money you put in, the more tax you avoid. When you use the money in your account to pay for out-of-pocket family care expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you will save as much as 25% on out-of-pocket family care expenses.

Flexible Spending Accounts offer tax savings for your out-of-pocket medical and dependent care expenses. Most people save as much as 25% on each dollar that is set aside.



How does the FSA work?

When you enroll in the FSA plan, you estimate the amount of health and dependent care expenses you expect to incur during the plan year. You have that amount deducted from your paychecks in equal amounts throughout the year. Although your actual salary remains the same, your taxable salary as reported to the government is reduced by the amount you put into your FSA.

After you enroll in the FSA, ASIFlex will send you a confirmation of your enrollment to your home address. As you incur eligible expenses throughout the plan year, you submit a claim along with documentation of the expense to be reimbursed with funds from your FSA account. You are not taxed on these reimbursements. After each claim, you will receive an account summary.

You can submit claims in a variety of ways, and you do not have to choose only one method. You can use a variety of submission methods during the year. You will have the following options:

- ASIFlex Online – Just go to www.asiflex.com and sign into your account. Scan your documentation and submit the claim.
- ASIFlex Mobile App – Just snap a picture of your itemized statement of services and submit via the mobile app for fast reimbursement! You can do this right from your provider's office!
- Manual Submission – Download a claim form from www.asiflex.com and submit with your documentation by toll-free fax or by USPS mail.

Federal rules state that you will only be able to be reimbursed for expenses you incur during the plan year, which runs from January 1, 2019 - December 31, 2019, and the accompanying FSA grace period which runs from January 1, 2020 - March 15, 2020. **Plan rules also state that if you do not use all of the money in your account, unused funds will be forfeited to the State.**

You can only change your election during the plan year as a result of a qualifying event. Also, your Social Security benefits calculations will be based on your lower taxable earnings figures. (You can check with your local Social Security office to explore any effects this may have on your benefits – which are usually very minor.) **The State of Delaware may require, at any time, employees to amend their Plan Year elections in order to maintain qualified status under the Plan.**

The State of Delaware has contracted with ASIFlex to perform certain administrative functions for the Plan. ASIFlex processes all claims for the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. If you have any questions concerning claims, please contact ASIFlex, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: asi@asiflex.com, or on-line at www.asiflex.com.

ENROLLMENT

2019 Enrollment Action Checklist

- **READ** your 2019 FSA Benefits information in this booklet.
- **PLAN** your out-of-pocket health and dependent care expenses for January 1, 2019 through December 31, 2019.
- **ENROLL** in the FSA plan for 2019 by visiting de.gov/statewidebenefits.

Important Reminders

- Open Enrollment is the **ONLY** time during the year you can enroll in Flexible Spending, unless you experience a qualifying event (see below).
- Enrollment is **REQUIRED EACH YEAR** during Open Enrollment if you wish to continue your participation in Flexible Spending.
- FSA elections are irrevocable for the Plan Year. You may only change your election during the plan year if you, your spouse, or a dependent experience a qualifying event **AND** your desired election change corresponds with that event.
- Claims must be filed by **April 15th** following the end of the Plan Year. There are no exceptions to this rule. After that, your account will be closed and any balance remaining will be forfeited to the State of Delaware in accordance with federal regulations.

Eligibility: All Active State Employees who are benefit eligible*; and have been employed by the State of Delaware for 90 days or more, counting the employment commencement date as the first day.

** NOTE: If an Employee, the spouse of an Employee, or anyone else on behalf of the Employee contributes to a Health Savings Account (HSA) owned by either the Employee or the Employee's spouse, the Employee is not eligible to enroll in the Flexible Spending Account (FSA), unless it is a limited purpose Flexible Spending Account (FSA) as outlined in IRS Publication 969. The State of Delaware does not offer a Limited Purpose FSA.*

The Plan Year is the twelve-month period from January 1 through December 31 of the same calendar year.

New Employee Enrollment. Benefit eligible employees may enroll effective the first day of the month after completing the **initial waiting period of 90 days** to participate for the remainder of that plan year. You may enroll by completing an enrollment form available from your Human Resources Office or online at de.gov/statewidebenefits. Enrollment forms should be sent by the **first of the month preceding the date of eligibility** to ensure timely enrollment. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until a qualifying event occurs that would justify a mid-year election change.

Enrollment during Open Enrollment. Open enrollment for the 2019 Plan Year will be held **November 1, 2018 through November 16, 2018**. You may enroll online during open enrollment each year for the upcoming Plan Year. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until a qualifying event occurs that would justify a mid-year election change.

Enrollment during the Plan Year. You may enroll during the plan year **ONLY** if you experience a qualifying event and the enrollment corresponds with a change in eligibility caused by that event. See the **Making a Change Section** for more information. The Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan have slightly different rules regarding making an election change or enrolling mid-year. Forms are available from your Human Resources office or online at de.gov/statewidebenefits.

MAKING A CHANGE

Except as specified in this section, your election under the Plan is irrevocable for the Plan Year. It is the employee's responsibility to file a change with their agency's Human Resources Office. The election change request must be filed within 31 days of the date of the qualifying event and becomes effective on the 1st of the month following the event or the date the form is signed whichever is later and upon the approval of the request. Requests received after 31 days will not be approved.

You may change your election if you, your spouse, or a dependent experience an event listed below which results in a gain or loss of eligibility for coverage under the State of Delaware Health Care Flexible Spending Account Plan or Dependent Care Flexible Spending Account Plan or a similar plan maintained by your spouse's employer or one of your dependent's employer and **your desired election change corresponds with that gain or loss of coverage**. Changes are only allowed if one of the specific events listed below has occurred that caused the needed change in your account. Otherwise, your election is effective through the end of the plan year.

Events 1 - 3 apply to the Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan.

1. Your legal marital status changes through marriage, divorce, death or annulment.
2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for dependent care because he or she turned 13, then that is a loss of a dependent under the Dependent Care Flexible Spending Account Plan, but not under any of the other plans.
3. You, your spouse or any of your dependents have a change in employment status (termination, retirement, new employment, change from part time to full time or vice versa) **that affects eligibility**, the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account with the State of Delaware or a plan maintained by your spouse's or any dependent's employer. Please see page 5 for specifics related to termination of employment from the State of Delaware.

Events 4 - 6 apply to Health Care Flexible Spending Account Plan, but not the Dependent Care Flexible Spending Account Plan.

4. You are served with a judgment, decree or court order, including a qualified medical child support order regarding coverage for a dependent. If the order requires you to pay for medical expenses not paid by insurance for a dependent child, then you may add or increase coverage under the Health Care Flexible Spending Account Plan. If the order requires that another person pay for medical expenses not paid by insurance for the dependent child, then you may drop or reduce coverage under the Health Care Flexible Spending Account Plan.
5. If you, your spouse or a dependent becomes entitled to and covered under Medicare or Medicaid, you may **drop or reduce coverage** under the Health Care Flexible Spending Account Plan.
6. If you, your spouse or a dependent loses eligibility and coverage under Medicare or Medicaid, you may **add or increase coverage** under the Health Care Flexible Spending Account Plan.

Events 7 - 8 apply only to the Dependent Care Flexible Spending Account Plan.

7. You change dependent care providers (including school or other free provider). You may make a corresponding change to your Dependent Care Flexible Spending Account and your future salary reductions if you change dependent care providers.
8. You may make a corresponding change to your Dependent Care Flexible Spending Account and your future salary reductions if your dependent care provider who is not your relative changes your costs significantly. A relative is any person who is a relative according to Code §152(a)(1) through (8), incorporating the rules of Code §152(b)(1) and (2).

Your Salary Reduction amount for a pay period is, an amount equal to the annual contribution for your FSA election, divided by the number of pay periods in the Plan Year following your effective date. If you increase an election under the Health Care Flexible Spending Account Plan or Dependent Care Flexible Spending Account Plan, your salary reductions per pay period will be an amount equal to your new reimbursement limit elected less the salary reductions made prior to such election change, divided by the number of pay periods remaining in the Plan Year beginning with the election change effective date.

Any increase in your election may include only those expenses that are incurred during the period of coverage on or after the effective date of the increase. Your coverage for the remaining period of the year shall be calculated by adding the amount of contributions made prior to the change to the expected contributions after the effective date of the change and subtracting prior reimbursements.

TERMINATION/RETIREMENT

Termination of participation. Your participation will end on the date in which you cease to be an Active Employee because of Retirement, Termination of Employment, Layoff, Reduction in Hours, or any other reason. Except as specified in the section on Coverage Continuation (COBRA), **Health Care expenses incurred while you are not a participant will not qualify for reimbursement.** Participation in the Health Care Flexible Spending Account ends on the day of termination or retirement, or on the date of your last paycheck with an FSA deduction. You may continue to file for Dependent Care expenses incurred during the Plan Year after the end of your participation.

Should you return to work as an eligible employee within 30 days during the same Plan Year, your participation will be reinstated as it was. If you return after 30 days during the same plan year, you will have the option of reinstating your coverage at the same annual level you had prior to your termination or reinstating your coverage at the same per pay period amount with a reduced annual amount. Should you choose the same annual amount, your per pay period contributions will be adjusted so that your total contributions for the year will equal your annual coverage amount. You have 31 days after you return to work during the same Plan Year to make a new election for the remainder of the Plan Year (not to exceed the annual plan maximum).

Your participation will also end at the end of the expiration of the Period of Coverage, if the Plan is terminated, or if you a file false or fraudulent claim for benefits.

Coverage Continuation (COBRA). To the extent required by COBRA, a participant or his/her spouse or dependent may elect to continue the coverage elected under the Health Care Flexible Spending Account Plan even though the participant's or his/her spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

- 1) Death of the participant;
- 2) Termination (other than for gross misconduct) or a reduction in hours;
- 3) After retirement;
- 4) Divorce of the participant; or
- 5) A dependent child ceases to be a dependent under the terms of this plan.

When the Plan is notified that one of the above events has occurred, the right to choose **continuation coverage** will be provided to each eligible person(s) if, **on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments.** The right to elect to continue ends **60 days** from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their Human Resources Office of the occurrence of an event described in bullet points 4 or 5 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. **Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by**

the Administrator. An administrative charge of 2% is assessed for each premium paid for continuation coverage.

Participants on Leave. To maintain Health Care FSA coverage, you must make arrangements **PRIOR** to going on **UNPAID** leave with your Human Resources Office to pay for coverage after you return from unpaid leave. If you have been on unpaid leave for longer than 30 consecutive days and did not elect to catch up contributions when you return, the election and corresponding coverage will be revoked (effective on the last day worked). Once your coverage is revoked, your ASIFlex Card will be immediately suspended.

A new election may be made within 31 days of return to work, effective for coverage the first of the month following approval of the submitted form. However, no coverage will exist for months in which no contributions were made if the participant had not elected to catch up contributions prior to the end of the 31 days. There will be a hold put on a participant's account (no claims will be paid) if contributions are not received on two consecutive payrolls and no leave form has been filed with your Human Resources Office.

Dependent Care expenses are not eligible for reimbursement during a period of **PAID or UNPAID** leave. Because of this, you may choose to have your deductions stopped prior to going on a period of leave. When you return to work, you will have 31 days to reinstate your coverage with the same or a new annual election.



It is the responsibility of the Employee to ensure arrangements are made **PRIOR** to going on an **UNPAID** leave with your Human Resources Office to pay for Health Care FSA coverage after returning from unpaid leave. If you have been on unpaid leave for longer than 30 consecutive days and did not elect to catch up contributions when you return, the election and corresponding coverage will be **REVOKED** (effective on the last day worked). **Once your coverage is revoked, your ASIFlex Card will be immediately suspended.**

Health Care FSA Participants called to Active Duty in the middle of the plan year. If you are a military reservist who is called to active duty for at least 180 days and are a Health Care FSA participant, you may request a Qualified Reservist Distribution (QRD) to access funds that might otherwise be forfeited. Requesting a QRD will allow you to access funds you have set aside in your Health Care FSA without incurring eligible expenses to seek reimbursement. If you request a QRD, the Plan will pay you the amount contributed to the Health Care FSA, as of the date of the QRD request, minus any reimbursements received as of the date of the request. QRDs are subject to employment taxes and will be included in your gross income and wages. A QRD will be reported as wages on your W-2 for the year in which the QRD is paid.

Once you request a QRD, you will forego the right to claim any additional expenses incurred while you were an active State employee. However, if you return from your military leave and re-enroll in the State of Delaware's FSA program during the same plan year, you may claim expenses incurred during your NEW period of coverage. All requests for a QRD must be submitted by the end of the FSA grace period (March 15th) following the close of the previous plan year. **For example**, if you would like to submit a request for a QRD for the 2019 plan year, you must submit this request no later than March 15th, 2020.

If you have questions about electing to receive a QRD, please contact your benefit representative for additional details.

ESTABLISHING AND USING YOUR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Estimate your family's annual out-of-pocket health care expenses. You may include expenses for anyone who is a qualified dependent for tax purposes. (There are exceptions for the expenses of children of divorced parents. Please review IRS Publication 502 at www.asiflex.com, or consult with your personal tax advisor for further information.) When calculating your annual election, include predictable expenses only.

2019 Plan Year Maximum \$2,700.00

2019 Plan Year Minimum \$50.00

The Affordable Care Act states that an individual is not allowed to have more than the federal maximum per plan year allocated to a Health Care FSA. If you have a spouse who has access to a Health Care FSA through his/her employer, you may each set aside up to the \$2,700 maximum through your respective employers, for a total of \$5,400 per household.

Qualifying Health Care Expenses include all medical, dental and vision expenses not covered or not reimbursed by insurance which are **incurred by you or your eligible dependent (definition available at www.asiflex.com) during the Plan Year or Grace Period** for health care as defined in Section 213(d) of the Internal Revenue Code. Please refer to the following list, or the Eligible Expenses Listing and IRS Publication 502 (available at www.asiflex.com) for further details on qualifying expenses. **Expenses qualify for the health care FSA based on when they are incurred, not when they are paid. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.** Please review the eligible expense listing at www.asiflex.com, or contact ASIFlex at asi@asiflex.com or (800) 659-3035 if you have any questions regarding particular expenses.

Below is a partial listing of qualified health care expenses. Expenses can only be claimed based on the date incurred regardless of the date you are billed or pay for the expense.

- Deductibles
- Co-pays
- Doctor's fees
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Prescription drugs
- Chiropractor's fees
- Over-the-Counter health care products such as bandages, sunscreen, first aid kits, diagnostic tests/monitors, etc.
- Insulin
- Orthodontia/braces (See details on page 8)
- Routine physicals
- Hearing aids including batteries
- Transportation expenses related to seek health care
- Medical equipment

Non-Qualifying Health Care Expenses

This is a **partial** list of related items that **do not** qualify under the Plan. There may be other items that do not qualify that are not listed here.

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
- Clip-on or non-prescription sunglasses
- Warranties & insurance premiums
- Toiletries
- Long-term care expenses
- Over-the-counter drugs and medicines (without a prescription)
- Medicines, drugs, herbs, or vitamins for general health and not used to treat a medical condition
- Expenses that are merely beneficial to your general health (e.g., vacations)
- Health club dues

NOTICE - Important Information Regarding Over-the-Counter Health Care Products

Although over-the-counter (OTC) *drugs and medicines* require a prescription in order to be reimbursed by a flexible spending account (FSA), there are many other OTC health care products that are not a drug or medicine ***that do not require a prescription!*** That's right! Take a look at what you can get without a prescription!

FSA☑ OTC PRODUCTS - NO PRESCRIPTION REQUIRED
Bandages, Band-Aids
Breast pumps, nose saline spray/drops, nasal aspirator, medicine dropper, ear syringe, etc.
Diabetic supplies, insulin, glucose monitor, testing strips, syringes, sharps containers, diabetic cases/coolers
Denture adhesives
Eye care, reading glasses, contact lens cleaners/storage kits, eye patches
Family planning, condoms, contraceptive creams, fertility monitors, ovulation prediction kits
First aid kits, first aid supplies
Glucosamine, arthritis formula
Hearing aids, batteries
Incontinence supplies, adult diapers, pads, absorbent underpads
Joint support bandages/braces, wrist, hand, neck, elbow, knee, ankle, etc.
Medic-alert bracelets or necklaces
Medical equipment and repair; crutches, canes, walkers, wheelchairs
Medical monitoring/testing devices, blood pressure monitors, blood glucose testing kits, cholesterol test kits, colorectal cancer test kits, etc.
Orthopedic and surgical supports, aqua casts, splints
Ostomy products, catheters
Sunscreen, SPF15 and higher
Pill holders, pill splitters
Prenatal vitamins
Vaporizers, humidifiers, thermometers

FSA☑ Most drug stores now have online FSA stores where you can shop for eligible FSA products. Go to www.asiflex.com and click on the FSA Store banner for comprehensive listings of OTC products that do not require a prescription.

FSARx☑ OTC *drugs and medicines* are eligible **with a prescription**. This includes pain relievers, allergy/sinus medicines, antibiotic treatments, canker/cold sore medicines, cold/cough/flu remedies, laxatives, smoking cessation patches/gum, sleep aids, sedatives.

Orthodontic expenses may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable. You may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed. Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed. Claims for the entire fee paid at the beginning of treatment will not be processed, nor will claims for an entire year's payments made at the beginning of the year be processed. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed. **If you have questions about using your Health Care FSA dollars for orthodontia expenses, visit www.asiflex.com or email asi@asiflex.com.**

Health Care FSA Eligible Dependents - Expenses for you and your spouse are automatically eligible for reimbursement through the Health Care FSA. Federal rules stipulate that expenses for your children or tax dependents will qualify for reimbursement through the program if one of the following criteria are met:

- 1) The individual must qualify as a tax dependent, as either a Qualifying Child or a Qualifying Relative:
 - a. **Qualifying Child** – in order for someone to qualify as a **tax dependent** as a Qualifying Child, the individual must:
 - Be the taxpayer's child (including an adopted child, stepchild or eligible foster child), brother, sister, stepbrother, stepsister or a descendant of one of these relatives;
 - Be under the age of 19 (age 24 if a full-time student); and
 - Live with the taxpayer for more than half of the year; and **NOT** have provided over half of his or her own support during the year and cannot be claimed as a "qualifying child" by any other taxpayer.

OR

- b. **Qualifying Relative** – in order for someone to qualify as a **tax dependent** as a Qualifying Relative, the individual must:
 - Be a blood relative or reside with the taxpayer if not a blood relative; • Receive over half of his/her support from the taxpayer; and
 - Be a US citizen.

OR

- 2) Under the health care FSA, you may also include qualified expenses for your adult child(ren), even if they are not considered a tax dependent, until the end of the calendar year in which your child(ren) reaches age 26. In order to be eligible, the individual must be a "child" of the taxpayer (son, daughter, stepson, or stepdaughter) or an eligible foster child and be age 26 or younger for the entire plan year in which medical expenses are claimed. Your child does not need to live with you in order for you to claim his/her health expenses that you have incurred on his/her behalf. Please see IRS Notice 2010-38 for further information.

Receive health care services. A health care expense is **incurred** when the services are provided that create the expense. You must receive the services before you file a claim for those services.

File claims. After you have received the health care services and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASIFlex. See **Flexible Spending Account Claims** for details on claims filing. Extra claim forms are available at www.asiflex.com or de.gov/statewidebenefits.

Grace Period. If you are a participant as of December 31st of a Plan Year, you may continue to incur expenses through March 15th of the following year to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year's funds first unless you request otherwise.

Example: *If you have \$50 remaining in your 2018 health flexible spending account as of January 1, 2019 and incur an expense for \$100 on February 10, 2019, this claim will be paid using \$50 from your 2018 FSA and the remaining \$50 from your 2019 FSA. If you do not want a claim for services provided January 1st through March 15th paid out of the old plan year, please write a note and enclose it with your claim form.*

Receive reimbursements. ASIFlex will review your claim, and if approved will reimburse you for the medical expenses within one to three business days of their receipt of the claim.

Payment from your Health Care Flexible Spending Account will be made up to the approved amount of your claim or your remaining annual election, whichever is less. Payment is not limited to the amount in your account at the time of your claim. Your per pay contributions will continue for the remainder of the Plan year.

THE ASIFLEX DEBIT CARD FOR YOUR HEALTH CARE EXPENSES

The ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses for you, your spouse and/or any qualified dependents. The IRS has stringent regulations regarding appropriate use of the ASIFlex Card, such as **where the card can be used, and when follow-up documentation is required. Use of the ASIFlex Debit Card is not paperless and DOES NOT eliminate paperwork.** The ASIFlex Debit Card is a great benefit, but it is important that you take a moment and understand how it works.

Where can the ASIFlex Debit Card be used?

Per IRS regulations, the ASIFlex Debit Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

- 1) **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The ASIFlex Card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- 2) **Inventory Information Approval System (IIAS):** The IRS also allows the ASIFlex Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your ASIFlex Card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the ASIFlex Card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The ASIFlex Card will work at these stores, even if the MCC does not indicate it is a health care provider. However, you will not be able to pay for OTC drugs or medicines with the ASIFlex Card, even if you have a prescription.

A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debitcards. **Purchases at these stores will never require follow-up documentation provided the merchant has identified the product as FSA eligible!**

If you use the ASIFlex Card at merchants that have implemented the Inventory Information Approval System (IIAS), you will not be able to pay for OTC medicine with the ASIFlex Card, even if you have a prescription on file with ASIFlex. You will be required to submit a reimbursement request, along with a copy of the prescription and the cash register receipt in order to be reimbursed for these expenses. You can also submit this online or via the mobile app.

Do I have to turn in documentation when paying with the ASIFlex Card?

If you use the ASIFlex card, you are only required to submit backup documentation if the transaction is unable to be electronically substantiated.

Which claims can be electronically substantiated?

ASIFlex Debit Card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of three other criteria are met. Transactions are electronically substantiated if:

- ✓ The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the **employer-sponsored** health, vision or dental plan that participant has elected;
- ✓ The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or
- ✓ The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies (e.g., Band-Aids, contact lens solution, etc.) and prescription medication (this system restricts purchases with the ASIFlex Card to FSA-eligible expenses).

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

What happens if I don't submit requested documentation?

As detailed above, there are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation will be required to substantiate the transaction, in accordance with IRS Regulations. When follow up documentation, or a statement of services is required, ASIFlex will send you an e-mail or letter requesting this documentation. The requested information should include the following information: name of provider, name of member (or member's spouse or dependent), date the service was provided, brief description of the service(s) provided, and the amount that was your responsibility.

ASIFlex will send the initial request for follow up documentation within a few days of the ASIFlex Card transaction. Should you not comply with the request, ASIFlex will make a second request in approximately three weeks. Should you not comply with the second request, a third notice will be sent to you stating that the ASIFlex Card has been "suspended" because the requested documentation was not received by ASIFlex.

When you use the ASIFlex Card for a transaction requiring documentation, those dollars are identified as "overpaid" within your FSA account until the transaction is substantiated.

If you submit a manual claim before the ASIFlex Card transaction is substantiated, the dollars associated with the manual claim will be used to offset the overpaid dollars from the ASIFlex Card transaction. This will prevent the manual claim from being reimbursed in part, or in full, depending upon the dollar amount of the manual claim. Once the ASIFlex Card transaction is substantiated, the manual claim used to offset the ASIFlex Card transaction will be reimbursed in full. See the following examples for further explanation:

Example 1: John goes to the dentist and pays \$200 for a root canal with his ASIFlex Card. He then receives a notice from ASIFlex requesting follow up documentation. John submits the statement of services from his dentist along with the notice received from ASIFlex. ASIFlex reviews and processes the follow up documentation to substantiate the claim. John's FSA account will no longer be showing as "overpaid" since all follow up documentation was submitted.

Example 2: Lisa pays her eye doctor \$250 for contacts using her ASIFlex Card. ASIFlex sends Lisa a notice asking for follow-up documentation for the \$250 purchase. Prior to submitting the detailed statement from her eye doctor, Lisa submits a manual claim to ASIFlex for a \$100 prescription which she paid for out-of-pocket. ASIFlex will process the \$100 claim but no payment will be issued that day.

Instead, the amount of the manual claim will be used to offset the ASIFlex Card transaction. This will result in ASIFlex showing Lisa's overpaid amount reduced from \$250 to \$150. Two weeks later Lisa submits the follow up documentation for the ASIFlex Card transaction used to purchase the contacts to ASIFlex. ASIFlex will then process the supporting documentation for \$250 and Lisa will be issued a payment of \$100 for her manual prescription claim.

If you are unable to provide documentation for an ASIFlex Card transaction in question, you may submit expenses incurred out-of-pocket to offset the ASIFlex Card transaction. The expenses that are incurred out-of-pocket must not also be paid for using the ASIFlex Card.

Should you neglect to submit the requested documentation and the plan year comes to a to an end (following the Plan's provision for documentation to be submitted by April 15), ASIFlex will provide notice to the State of Delaware that the claim was not substantiated within the plan year as required by IRS Regulations. **If you are actively employed by the State of Delaware and do not repay your claims, a wage attachment will be processed to deduct the amount of the unsubstantiated claim/s from your pay.**

If you do not provide requested documentation and leave State of Delaware employment or retire, a W-2 will be provided to you for the year in which the funds were not repaid and these funds will be reported to the IRS as earnings for which taxes must be paid. See the following example for further explanation:

Example: *Lori's daughter Carrie goes to the dentist to receive a crown in 2019. Lori uses her ASIFlex Card for the \$750 expense. Lori terminates employment the following week. ASIFlex sends Lori three notices requesting follow up documentation, and receives no response or repayment from Lori. At the end of the plan year (following the grace period provision to April 15, 2020) ASIFlex will notify the State of Delaware of the overpayment. The State of Delaware will then issue a W-2 for 2020 in January, 2021, to the member and to the IRS, which will report the \$750 overpayment as taxable income.*



While the ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses, the ASIFlex Debit Card is **NOT** a paperless option and **DOES NOT** eliminate paperwork. There are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation **will still be required** to substantiate the transaction in accordance with IRS Regulations.

Concerns and questions regarding this process should be directed to ASIFlex at asi@asiflex.com or 1-800-659-3035.

Is there a cost for the ASIFlex Card?

Yes. There is a \$6.00 annual fee that will be deducted from your available balance in January 2019. There are no refunds for the ASIFlex Card if you terminate employment or use up your balance early in the plan year.

How do I request an ASIFlex Card?

You can request to receive an ASIFlex Card through the online enrollment site available during open enrollment, or by completing the ASIFlex Card application form found on the Statewide Benefits website. Generally, it takes about two weeks to receive the card once it has been requested.

Can I request additional ASIFlex Cards?

Yes. Everyone who requests a card will receive two ASIFlex Cards in the mail. If you would like additional cards, complete the ASIFlex Card application form and submit to ASIFlex. There is a \$5 fee for each additional set of ASIFlex Cards requested. Please note that all ASIFlex Cards will be in the name of the FSA participant.

I had an ASIFlex Card for 2018 and re-enrolled in the FSA for 2019. Will my 2018 card still be valid?

Yes, as long as the card is not expired and you have re-enrolled in the FSA program for 2019, your ASIFlex Card will be funded with your new annual election as of January 1, 2019. Please do not throw away your ASIFlex Cards from previous plan years until the expiration date on the physical ASIFlex Card passes. **If you have discarded or destroyed your ASIFlex Card and would still like to use the card in 2019, you will be assessed a \$5 replacement card fee for each additional set of cards you request. This fee is on top of the \$6 annual card fee.**

Can I use the ASIFlex Card to pay for OTC medicine at stores that have implemented IIAS if I have a prescription on file with ASIFlex?

No, you will not be able to pay for OTC medicine with the ASIFlex Card, even if you have a prescription on file with ASIFlex. You will be required to submit a reimbursement request, along with a copy of the prescription and the cash register receipt in order to be reimbursed for these expenses. However, you may use the card to purchase health care products that are not considered a drug or medicine.

ESTABLISHING AND USING YOUR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Estimate your total dependent care expenses for the Plan Year. Include predictable expenses only. **DO NOT** include medical or dental expenses for your dependents in the Dependent Care Flexible Spending Account election, these are claimed through your Health Care Flexible Spending Account.

Annual (household) Maximum \$5,000.00

Annual Minimum \$50.00

You and your spouse together may include up to \$5,000.00 **per calendar year** (\$2,500 in the case of a married individual filing a separate tax return for the plan year) or the lesser of your or your spouse's earned income for the plan year. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of \$250 per month if you have one dependent and \$500 per month if you have two or more dependents. In accordance with IRS guidelines, the State of Delaware examines Dependent Care FSA elections each year to ensure that the plan does not favor Highly-Compensated Employees* (HCE) as defined by the IRS. If the Plan is found to "discriminate" against non-highly compensated employees, the State of Delaware will reduce contributions made by HCEs in order to maintain qualified status under the Plan. Non-highly compensated employees are not affected by this rule.

**Highly Compensated Employees* for purposes of Dependent Care, are individuals who receive an annual compensation of \$120,000 or higher, as well as individuals who have been identified as key employees.

A Qualifying Individual is your Dependent who is **under the age of 13** (when services are incurred) or your Spouse or an older Dependent who is mentally or physically incapable of self-care who lives in your home at least 8 hours each day. If you are divorced, the Qualifying Individual must be your son or daughter for whom you have more than 50% physical custody. Please call ASIFlex before enrolling in this account if you have unique day care or joint custody arrangements. Be sure to notify your Human Resources Office within 31 days of a change in eligibility of a qualifying individual if you need to change your election.

A Qualified Provider can provide care in your home or outside your home. If the care is provided outside your home and the facility cares for more than 5 individuals, then it must be licensed by the State.

The expenses **may not** be paid to your spouse, a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred, or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

The Dependent Care Flexible Spending Account is an alternative to taking a “Tax Credit” allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the “Tax Credit” or the “FSA”. The IRS will not allow you to receive two tax breaks on the same expenses.

- A **Tax Credit** is allowed for child/dependent care expenses of up to \$6,000 per year for two or more dependents (\$3,000 per year for one dependent). You file for the “tax credit” on your annual tax return, at the end of the year. The credit is an amount equal to your dependent care expenses multiplied by a percentage determined by your combined adjusted gross income. The percentage decreases from a high of 35% to a low of 20% as your income increases.
- The **Dependent Care Flexible Spending Account** Plan allows a tax break on up to \$5,000.00 per year, \$2,500 if married filing separately, for any number of dependents; one, two, or more. You will experience “tax savings” throughout the year with every paycheck you receive. Employees who pay federal taxes of 15%, state taxes of approximately 6% and Social Security taxes of 7.65% would save around 28% of expenses through the Dependent Care Flexible Spending Account Plan. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care Flexible Spending Account Plan.

Generally those employees with a combined family income over \$31,000 will have a higher percentage tax break through the Dependent Care Flexible Spending Account Plan. Those employees with a combined income under \$31,000 generally will have a higher percentage tax break using the Tax Credit. **Please contact your tax advisor if you have questions about which is better for you.**

You are required to file Schedule 2 with your IRS Form 1040A or **Form 2441** with your IRS Form 1040 to support the amount redirected for the calendar year. This is for informational purposes. You will not pay taxes on the redirected amount. Payments made to you under this category are not taxable, but the amount redirected will appear on your W-2 form which informs the IRS that you have received a tax break on that expense.

Qualifying Dependent Care Expenses

Qualifying Child/dependent care expenses are those that you incur in order for you and your spouse (if married) to be gainfully employed that are considered to be employment-related expenses under Internal Revenue Code §21(b)(2) to the extent that you or another person (if any) incurring the expense is not reimbursed for the expense through any other Plan. **Only expenses incurred for care and wellbeing qualify for this tax break** (Kindergarten, summer school and private school expenses, food and transportation do not apply). Day camp fees incurred in order for you to work are allowable but overnight camps are not.

Refer to the Eligible Expense Listing and IRS Publication 503 (available at www.asiflex.com) for additional information. The purpose of Publication 503 is to assist people with their income tax filing. It does not address Dependent Care Flexible Spending Account Plans. However, most of the items listed as eligible for the tax credit in 503 can be claimed through your Dependent Care Flexible Spending Account. You can only claim expenses based on the date incurred (not paid as stated in 503). Please contact ASIFlex at asi@asiflex.com or (800) 659-3035 if you have any questions regarding particular expenses.

Qualifying Expenses are those that enable you to be gainfully employed including:

- Daycare centers
- Babysitters
- Nanny, Au Pair
- Before school/after school care
- Day camps
- Preschool, nursery school (not tuition)

Non-Qualifying Dependent Care Expenses

This is a **partial** list of items that **do not** qualify under the plan. There may be other items that do not qualify that are not listed here.

- Care that is not incurred in order for you to work or look for work
- Kindergarten or other educational expenses
- Amounts paid to your spouse or dependent or to your (or your spouse's) son or daughter who is under 19 years old at the end of the year
- Care for a child for whom you have 50% or less physical custody
- Care for a child age 13 or older who is not disabled
- Child support payments
- Elder daycare for a dependent with gross income over the Federal exemption limit
- Food, transportation or activity fees
- Overnight camps

Receive dependent care services. Dependent care expenses are **incurred** when the day care is provided. You must receive the dependent care services before you file a claim for those services.

File claims. After you have received the dependent care services, you may submit a claim for those expenses to ASIFlex. Extra claim forms are available by contacting ASIFlex or online at www.asiflex.com or de.gov/statewidebenefits. You can also submit claims online or via the mobile app.

You can have the dependent care provider sign the dependent care certification section of the claim form in lieu of providing separate documentation for dependent care claims.

You must provide the tax identification number or Social Security Number of the child/dependent care provider with your federal income tax return. Please check with your child/dependent care provider (**before** enrolling in this category) to be sure that you are able to obtain his/her tax I.D. or Social Security number.

Grace Period: If you are a participant as of December 31st of a Plan Year, you may continue to incur expenses through March 15th to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year's funds first unless you request otherwise.

Example: *If you have \$50 remaining in your 2018 flexible spending account as of January 1, 2019 and incur an expense for \$100 on February 10, 2019, this claim will be paid using \$50 from your 2018 FSA and the remaining \$50 from your 2019 FSA. If you do not want a claim for services provided January 1st through March 15th paid out of the old plan year, please write a note and enclose it with your claim form.*

Receive reimbursements. ASIFlex will review your claim, and if approved will reimburse you within one to three business days of their receipt of your claim up to the amount you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from payroll.

Payment from your Dependent Care Flexible Spending Account will be made up to the approved amount of your claim or your current balance, whichever is less. Any portion of your claim which is not paid will be paid automatically as money is contributed from payroll. Total payments for the year are restricted to your annual election.

False or Fraudulent Claims. If ASIFlex believes that false or fraudulent claims have been submitted, ASIFlex will investigate the submitted claims and forward, with all investigational findings, to the State of Delaware's Statewide Benefits Office for further investigation. In the interim, ASIFlex will deny your claim and notify you that your account has been placed on hold until the situation has been resolved. The Statewide Benefits Office will make a decision as to whether your participation will be terminated in FSA and whether to recover any funds that may have been fraudulently obtained. The State of Delaware has the authority to deny claims found to be false or fraudulent and to terminate your participation in the FSA in accordance with its discretionary duty as the Plan Administrator. The State of Delaware may take legal or disciplinary action against a member found to have committed fraud.

FLEXIBLE SPENDING ACCOUNT CLAIMS

- Claims processed daily – within 1-3 business days of receipt of qualified claim.
- File Claims Online! Go to www.asiflex.com, account detail section, and upload your scanned documentation.
- Go mobile! Snap a picture of your documentation and submit via the ASIFlex Mobile App.
- Fax Claims: 1-877-879-9038
- Mail Claims: P O Box 6044 Columbia, MO 65205-6044
- Go to www.asiflex.com for claim forms and personal account information.
- Direct deposit is available for claims payment – Sign up through your online account.
- Direct deposit notices are sent via E- mail or USPS the day that payment is initiated.
- Email/Text Alerts – Sign up through your online account.

Allowable expenses must be incurred during the portion of the Plan Year or Grace Period that you are a participant. **Claims must be filed by April 15th following the end of the Plan Year. After that, your account will be closed and any balance remaining will be forfeited to the State of Delaware in accordance with federal regulations.** If April 15th is a holiday, Saturday, or Sunday, then claims must be filed by the first business day following April 15th.

You must submit your claim along with **copies** of itemized statements of service **from the provider** to serve as proof that you have incurred an allowable expense in order to receive payment. Itemized Statements of service are **required to include**, the **provider's name/address**, patient name, the **date(s) of service**, a **description of the service(s)**, and the **expense amount**. Copies of personal checks and paid receipts, without the above information, are not acceptable. **Documentation or copies will not be returned.**

For over-the-counter supplies that do not require a prescription, the receipt or documentation from the store must include the name of the item pre-printed on the receipt. **Claim forms are available online at www.asiflex.com or de.gov/statewidebenefits.**

Purchases for general good health are not eligible. Claims for items that are purchased for an existing medical condition must be accompanied by a letter from your attending physician stating the medical condition and the items that are required as treatment for that specific medical condition (if they would otherwise not qualify as a general good health item). A sample letter is available at www.asiflex.com. This letter can be used as support for 12 months from the date of the letter. To learn which expenses may require a letter from your attending physician, view the Eligible Expenses listing at www.asiflex.com.

Electronic Communications – You can sign up to receive email and text alerts instead of mail. Sign into your account at www.asiflex.com and update your account settings under “Manage Your Account.”

Direct deposit into the bank account of your choice is available for your claim payments. By using direct deposit you will not need to wait for a check to arrive and be deposited. A notice that a payment was made will be sent to you. To sign up for direct deposit, sign into your account at www.asiflex.com and update your account settings under “Manage Your Account.”

If you receive a check for reimbursement and forget to cash it, the check is valid for six months from the issuance date. If you have received a check and have not cashed it within six months, ASIFlex will attempt to contact you via email or postal mail, and will offer to reissue the reimbursement to you. If ASIFlex cannot reach you, the amount of the uncashed check will be reported and remitted to your state of residence’s unclaimed property division. For State of Delaware residents, remittance shall be made to the State of Delaware Department of Finance, Bureau of Unclaimed Property.

If you have unused funds at the end of the claims filing period, those funds are forfeited to the State of Delaware and used to a) offset reimbursements to health care FSA participants who terminate employment mid-year and have been reimbursed more than contributed at that point in time and b) pay ASIFlex’s administrative fees.

If a claim is denied in whole or in part, ASIFlex will notify the Participant in writing within 30 days of the date that ASI received the claim. This time may be extended for an additional 15 days for matters beyond the control of ASIFlex. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal ASI’s adverse benefits determination*

**If a claim for benefits is denied in whole or in part, or if the Participant believe that benefits under the Health Care FSA plan to which they are entitled have not been provided, an appeal process is available. Participants may appeal in writing by completing an Appeal Form from ASIFlex within 30 days to ASIFlex after the denial is received. If an appeal is not made within the above referenced timeframe all rights to appeal will be forfeited.*

ONLINE ACCESS

You can access your Health Care Flexible Spending Account and your Dependent Care Flexible Spending Account online 24/7. You can also view detailed eligible expense listings, view educational videos, read frequently asked questions, access claim and other administrative forms, read ASIFlex Card information, link to FSA Store and IRS forms and publications.

To access your account:

1. Go to asiflex.com
2. Select “**Online Access/Account Detail.**”
3. Click on the “**Participant/Account Detail.**”
4. Sign in using your User Name, Password and Security Image.

If you have not yet set up your account, simply click the “Create an Account” button and follow the instructions.